Prestwick Care Limited

Brooke House

Inspection report

Ronald Drive
Newcastle upon Tyne
NE15 7AY
Tel: 0191 2748484
Website: www.prestwickcare.co.uk

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This was an unannounced inspection which we carried out on 27 January 2015.

We last inspected Brooke House in May 2014. At that inspection we found the service was meeting all legal requirements.

Brooke House is a purpose built care home that provides personal and nursing care to a maximum of 50 older people, most of whom live with dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Due to their health conditions and complex needs not all of the people who used the service were able to share their views about the support they received.

We have made a recommendation about the management of some medicines with regard to the use of "as required medicines" and to ensure the correct procedure is adhered to for the administration of covert medicines when people lack mental capacity.

Summary of findings

Care records did not always reflect the care and support provided by staff.

People said they felt safe and they could speak to staff as they were approachable. Comments from relatives and people included, “I would say he is safe here.” And, “I definitely feel (Name) is safe from physical harm.” Another said, “I think my relative is safe, the staff are just so busy.” And, “I think the staff are caring, and (name) is safe, the staff are just so busy.” And, “(Name) is safe here.” We found at the time of inspection there were not enough staff always on duty to provide individual care and support to people. This was immediately addressed after the inspection as more staff were employed to be on duty.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

The necessary checks were carried out to ensure the building was safe and fit for purpose.

Staff were appropriately trained and told us they had completed training in safe working practices and were trained to meet people’s specific needs.

Brooke House was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training and had some understanding of the Mental Capacity Act 2005 (MCA) and Best Interest Decision Making.

Menus were varied and a choice was offered at each mealtime. The catering staff provided special diets which some people required. People commented, “The food isn’t bad, there’s plenty to eat.” And, “The food is lovely, the chef is great.” A relative commented, “The food looks excellent, it’s spot on, there is a very good choice on the menu.” Staff were sensitive when assisting people with their meals but we observed meal times were not well organised for people who lived with dementia.

Staff were knowledgeable about people’s needs and we observed that care was provided with patience and kindness and people’s privacy and dignity were respected. People said staff were kind and caring. Comments included, “The staff are canny, I couldn’t say anything bad about them.” And, “The staff are kind.” Another person said, “I love it here.” And, “Lovely girls here, all of them are good.”

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

Activities and entertainment were available for people. An activities committee was being formed to develop ideas for more activities and entertainment. People commented, “I go for a pub lunch every month.” And, “I sometimes sit and have a drink of lager in the evening.” Another person said, “I have been taken out in a taxi to visit my friends.” And, “We do lots of activities, dominos, cards, painting and sing-a-long.”

People were being supported to maintain some control in their lives. They were given some information in a format that helped them to understand if they did not read to encourage their involvement in every day decision making.

People had the opportunity to give their views about the service. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

The registered manager was introducing changes to improve the quality of care and to ensure the service was well-led for the benefit of people who used the service.

We found one breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 in relation to record keeping, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Most aspects of the service were safe to ensure the safety and well-being of people.

Medicines were not all managed appropriately.

People were protected as staff were vetted before they worked in the home.

There were enough staff to meet people's needs in a timely manner.

Regular checks took place to make sure the building and equipment used to transport people were safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received the training they needed.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

People received appropriate health and social care. Other professionals were involved to assist staff to make sure their care and treatment needs were met.

People's nutritional needs were met and specialist diets were catered for.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Staff were kind and caring but there was an emphasis on task centred care as staff did not have time to spend talking with people or engaging with them.

We found people who lived with dementia were helped to make choices and to be involved in daily decision making. However their meal time experience needed some improvement.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Visitors said they were involved and kept informed about their relatives care and any change in their condition.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Summary of findings

People did not always receive support in the way they needed because staff did not have detailed guidance about how to deliver people's care. Care plans were not all in place, or detailed to meet people's care and support requirements.

There were activities and entertainment available for people. People enjoyed going out in the community supported by staff.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Not all aspects of the service were well-led.

Requires Improvement

A registered manager was in place. Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

The registered manager was introducing changes to improve the quality of care and to ensure the service was well-led for the benefit of people who used the service.

Staff and people who used the service said communication was becoming more effective.

The home had a quality assurance programme to check on the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received safe care that met their needs.

Brooke House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 January 2015 and was unannounced. The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people including those who live with dementia. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We also undertook general observations in communal areas and during mealtimes.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. During the inspection we spoke with 15 people who lived at Brooke House, four relatives, the registered manager, the deputy manager/clinical lead nurse, nine support workers, one visiting professional, the house keeper and the cook. We observed care and support in communal areas and looked in the kitchen and three people's bedrooms with their consent. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for nine people, the recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We received some information of concern from these agencies and saw the action that had been taken to address these concerns at the inspection.

Requires Improvement

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Comments from relatives included, "I would say he is safe here." And, "I definitely feel (Name) is safe from physical harm." Another said, "I think my relative is safe, the staff are just so busy." And, "Staff work hard but don't have enough time to do a lot of the things they should be doing." Another relative commented, "I think the staff are caring, and (name) is safe, the staff are just so busy." And, "(Name) is safe here." A staff member said, "Staffing levels have been a problem, but it's been getting better over the last six months with more permanent staff." A person said, "Staff so busy, they don't come straight away." A GP said, "The staff are very attentive and care for patients, they show the appropriate level of concern, are usually on the ball, there could do with being a few more staff."

We had received some concerns about staffing levels before the inspection with regard to the numbers of staff on duty. The registered manager and quality assurance manager told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of inspection there were two nurses and seven care workers on duty to care for 46 people. We had concerns staffing levels were not sufficient to meet the current level of need and they were not consistently maintained each day. The registered manager confirmed they would review this.

Staff rosters showed only two care workers were available on some floors. Staff told us staffing levels also reduced when some workers went off duty at 3:00pm and they were not replaced. We saw agency staff came on duty during the inspection to replace absent staff, however they were not effective. They stood and did not interact with people and did not intervene as they said they did not know the care and support needs of people. A staff member commented, "There are enough nurses now and they cover for holidays usually by working additional shifts." However we were told one nurse was available to cover the home on some occasions recently and staffing rosters showed this was the case when there should have been two. The registered manager told us there had been a shortfall in staff, as one of the nurses had an unexpected family emergency and had returned home overseas. She also said she was recruiting staff and the plan was to have three care workers to work on each floor plus the two nurses. We checked after the inspection to see the action that had been taken and this had been actioned so a minimum of three care workers were available for each floor.

We checked the management of medicines. People had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. We observed a medicines round and saw the staff member remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff employed at the home had been recruited correctly as the necessary checks had been carried out before they began work in the home. There was one matter with regard to Disclosure and Barring Service (DBS), which checks if people have any criminal convictions, for people on work placement in the home. We checked this with the registered manager and quality assurance manager who said they would follow this up immediately. We spoke with other staff and looked at personnel files to check if they had been appropriately recruited. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. References had been obtained and the results of their DBS checks had been received before they began employment in the home.

Medicines were appropriately stored and secured within the treatment room. However, we found concerns with certain aspects of medicines management. Medicines were not always secured in the medicines trolley. During a medicine round on the top floor we observed two tablets were left unattended, on the top of the trolley whilst the worker administered medicines to a person in the dining room. This presented a hazard as there were people in the corridor who could have taken these, before the member of staff removed the tablets. This was discussed with the nurse and they recognised the risks involved.

Up-to-date policies and procedures were in place to support staff and to ensure medicines were managed in accordance with current guidance. There was no written guidance for the use of "as required" medicines, and when these should be administered to people who showed signs

Is the service safe?

of agitation and distress. The nurse had a good understanding of when to offer "as required medicine." For example, they checked if a person was experiencing pain and offered the "as required medicine."

Record showed three people received covert medication. Covert medicine refers to medicine which is hidden in food or drink. No documentation was available to show why this was required, other than the record referred to the need and that it had been authorised by the GP. There was no evidence to show if all other ways had been exhausted before the decision was reached and there was no evidence that the decision was reviewed. We saw the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. "A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

We recommended the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

We were informed ten safeguarding incidents had been raised by the registered manager and reported to the local authority since the last inspection. The alerts had been investigated and where necessary corrective action had been taken by the provider. Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They told us, and records confirmed they had completed safeguarding training. Staff were able to tell us how they would respond to any allegations or incidents of abuse and were aware of the lines of reporting within the organisation. One person commented, "I'd report any concerns to the registered manager." Another staff member said, "I know what to do, I've had safeguarding training." They were aware of the provider's whistle blowing procedure and knew how to report any worries they had.

Records showed that risk assessments such as for tissue viability, nutrition, falls and oral health were in place to reduce the risk to people's safety. They were regularly reviewed and evaluated. Referrals were made where problems had been identified. For example, a person who had suffered a number of falls was referred for community rehabilitation.

A personal emergency evacuation plan (PEEP) was also available for each person taking into account their mobility and cognitive awareness. This was if the building needed to be evacuated in an emergency.

The registered provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Records we looked at included; maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety checks. Regular checks were carried out and contracts were in place to make sure the building was well maintained and equipment was safe and fit for purpose.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments included, "We are encouraged to progress our careers." And, "I have learnt a lot since I came here." Another person said, "There's loads of training." Another staff member said, "I'm going on some training soon." And, "I've done training about dementia awareness.

The staff training record showed all staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. The training gave staff some knowledge and insight into people's needs and this included a range of courses such as; dementia care, nutrition, distressed behaviour, Parkinson's disease and equality and diversity. They had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Staff told us they were supported to carry out their caring role. One staff member said; "I feel well supported." Another said; "The nurses are nice, they are approachable." Care workers said they received regular supervision every two months from the senior care worker and nurses received supervision from the registered manager. Staff said they could approach the management team at any time to discuss any issues. They also said they received a six monthly appraisal to review their work performance. They said they felt well supported by colleagues and senior staff. A nurse said, "Nurse meetings have started since the new manager came and these have been useful."

CQC monitors the operation of DoLS. DoLS are part of the MCA. These are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that a number of applications were being considered and two people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary for people's capacity to make particular decisions. For example, with regard to their health care.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. People confirmed they were asked for permission before receiving any care. Comments included, "Staff will ask me if I want any help." Another person said, "Staff explain what they need to do before they do it."

People were positive about the food saying they enjoyed the food. One person commented, "The food isn't bad, there's plenty to eat." Another said, "Too many sweet things, although the apple pie was nice." And, "The food is lovely, the chef is great." A relative commented, "The food looks excellent, it's spot on, there is a very good choice on the menu." We saw the midday meal was a light meal as the main meal was served at tea time. It consisted of soup followed by potato croquettes and chicken goujons or sandwiches followed by cake. The meal was well cooked and looked appetising and people enjoyed it. Drinks were available during the day with biscuits provided.

People's healthcare needs were met as records showed staff received advice and guidance when needed from specialists such as; physiotherapists, speech and language therapists, dieticians, specialist nurses and occupational therapists. People had regular access to their GP or district nurse when appropriate. One person said, "They look after me when I'm poorly." Another said, "The dentist, chiropodist and optician visit me here." Records were kept of visits and any changes and advice was reflected in people's support plans. For example, advice was available in one person's support plan from the speech and language team and the occupational therapist. For another person the physiotherapist and falls team were involved to advise about mobility and falls.

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. Staff commented, "Communication is good, it's getting better." And, "Handovers are a good forum for discussion about individual people."

The environment was designed to help people who lived with dementia to maintain some independence. The

Good

Is the service effective?

premises were 'enabling' to promote people's independence, and involvement. People were able to identify different areas of the home. There was appropriate signage and doors such as lavatories, bathrooms and bedrooms had large signs for people to identify the room to help maintain their independence. Memory boxes that had been completed, contained items and information about people's previous interests and they were available outside some people's rooms to help them identify their room. They also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

Requires Improvement

Is the service caring?

Our findings

Most people we spoke with were complimentary about the staff. Comments included, "The staff are canny and I couldn't say anything bad about them." And, "The staff are kind." A relative commented, "I think the care is fine, they are looking after him, I am quite happy with him here." Another person said, "I love it here." And, "Lovely girls here, all of them are good." A member of staff commented, "We are encouraged to sit and talk with the residents when possible, but we don't have much time." Another person said, "Staff are kind, they'll do anything for you." Another relative commented, "I think the staff are caring, they are just so busy."

During the inspection there was a relaxed atmosphere in the home. Regular staff interacted well with people who we saw were relaxed with them. Staff engaged with people in a sensitive and quiet way. Staff were enthusiastic but they were kept busy and this was evident as they did not have time to sit and talk with people or encourage them. For example, a person who liked to sit in the corridor had been sitting for some time with their breakfast, but they had not been encouraged to eat it. Another person was asleep in a chair without arm rests and was starting to slip from the chair. Staff went by and did not observe this. We intervened to make staff aware of the risk of the person falling to the floor. The person was assisted to sit up but later another staff member came and assisted the person to a more appropriate chair in the lounge.

When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Care workers were caring and patient. For example, they talked gently to a person and reassured them as they got them into the lifting equipment and wheel chair.

Regular staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People's privacy and dignity was respected. Staff knocked on people's bedroom doors before they entered and could give us examples of how they respected people's dignity.

We saw the lunchtime meal on the three floors. Care workers were busy as they served meals and supervised people to eat in dining rooms, bedrooms and lounges. The dining experience could be improved on the second and third floor, as it was not well organised. People were served their first course but had to wait some time after they had finished for the next course. We were told the hot trolley was shared between the two floors so people had to wait for their next course until the trolley returned. On the second floor some people got up and left the dining room. We observed one person's meal was taken by some other person sitting at the table and staff had not noticed so had to obtain another meal after we intervened. The meal time organisation showed it was not an event that encouraged people who had problems with nutrition to eat well as they had to wait. It was also difficult for staff to monitor people's food intake. Staff provided prompts of encouragement in a quiet and unhurried way, however they did not always notice when people needed assistance. For example, some people were not helped to sit near to the table so it was easier to get their food to their mouth or to prevent it from spilling onto their lap. We discussed our observations with the registered manager who acknowledged that improvements were needed to enhance the mealtime experience.

Family members told us they were kept informed about any changes in their relative's condition. One relative said, "They will (staff) telephone me if (name) isn't well."

There was information displayed in the home and in the home's brochure about advocacy services and how to contact them. Advocates can represent the views and wishes for people who are not able to express their wishes. No one had an independent advocate at the current time as people had relatives involved.

Requires Improvement

Is the service responsive?

Our findings

People commented there were activities and entertainment. Comments included, "I go for a pub lunch every month." And, "I sometimes have a drink of lager in the evening." Another person said, "I have been taken out in a taxi to visit my friends." And, "We do lots of activities, dominos, cards, painting and sing-a-long." Another person said, "My family come and see me at any time." And, "I love mixing with people."

There was an activities programme advertised in reception and throughout the home. People were aware of the programme and spoke positively of the activities which were carried out individually or in groups. Activities included; arts and crafts, flower arranging, sing-a-long, music, board games, dominoes, quizzes, bingo and painting. A church service was also held in the home monthly. Outside entertainers regularly visited and included; pony therapy, a mobile tuck shop and singers. A relative said, "An activities committee has been formed by the activities person, we'll meet once a month to look at ideas to develop more activities." The activities person said, "Activities are arranged over seven days of the week and an activity is organised for morning and afternoon. New activity items have been purchased." The activities person also said, "I do 1:1 activities such as talking or painting with a person as they may not want to be in a group."

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Records confirmed that preadmission assessments were carried out before people moved into the home.

Regular reviews or meetings took place for people and their relatives to discuss people's care and to ensure their care and support needs were still being met. Relatives we spoke with said they were involved in meetings to discuss their relative's care. Comments included, "Staff are giving (name) the care and attention they need." And, "I'm always involved in reviewing (name)'s care plan." Another said, "I'm invited to meetings about my relative's care."

Record keeping for people was not consistent. Records showed that monthly assessments of people's needs were carried out but the records did not all reflect the changes that had taken place. For example, a person had lost weight in the last month but the review of the care plan stated, "Dietary intake remains satisfactory at this time." The person needed support at mealtimes and this was not clearly recorded in their care plan. However another person's records provided clear information about the loss of weight and action taken.

Staff knew the individual care and support needs of people, as they provided the day to day support, but this was not always reflected in people's care plans. The care plans did not give staff specific information about how the person's care needs were to be met. For example, one person's nutritional care plan stated, "Adequate diet, offer food choices, support and prompting may be needed." Another care plan stated; "(Name) does sometimes get low and cries. May also lose interest in her food if she's low." And another, "Prone to bedsores, reposition during the day." The care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. The registered manager said they would ask the nurses and senior care workers who were responsible for the care plans to get together to discuss the format.

Some people with distressed behaviour were referred to the behavioural team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague, or not in place for some other people who may show agitation or distress. For example, personal hygiene care plans stated, "Gets anxious needs reassurance." The care plans did not give staff detailed instructions with regard to supporting people when personal care was carried out. Information was not always available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. Risk assessments were not in place nor care plans to advise what staff should do and when a referral to a specialist behavioural team would be triggered if people refused to accept any assistance or refused to carry out their own personal care.

Some people had a 'This is Me' profile but it was not available for everyone. The information had been collected

Requires Improvement

Is the service responsive?

with the person and their family and gave details about the person's preferences, interests and previous lifestyle. It is important information and necessary for when a person can no longer tell staff themselves about their preferences.

We had concerns records did not always accurately reflect people's care and support needs.

This is a breach of Regulation 20 of the Health and Social Care Act 2008.(Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to make choices about their day to day lives. They told us they were able to decide for example; when to get up and go to bed, what to eat, what to wear and what they might like to do. Comments included, "I like to have a long lie." Another person said, "I can choose what I want to eat, if I don't like something, there's always something else." We saw information was accessible to help promote the involvement of the person and keep the person orientated. Pictorial aids and orientation aids, such as activity boards and menus were available.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example; the dietician for advice with nutrition. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans that were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained. Two complaints had been received since the last inspection which had been investigated and the necessary action taken. One relative said, "I made a compliant to the registered manager and I was happy with the outcome." Another relative said their complaint was still being investigated.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place who registered with the Care Quality Commission (CQC) in December 2014. The registered provider had been pro-active in submitting statutory notifications to the CQC, such as safeguarding notifications and notifications for serious injuries.

Staff said they felt well-supported. Comments included, "The registered manager is supportive." And, "I have no problem talking to the manager about anything." Another person said, "Since (Name) the registered manager took over, she has made a big difference." And, "I can approach the registered manager for help any time." Another person said, "I wouldn't hesitate to report anything to the registered manager, she is very approachable." And, "The registered manager's door is always open and she makes time to talk to you." A relative said, "I think things are much better now."

The registered manager said she had introduced changes to the home to help its smooth running and to help ensure it was well-led for the benefit of people who used the service. She responded quickly to address any concerns and readily accepted any advice and guidance. Changes or improvements were also being acted upon as a result of safeguarding investigations. For example, improvements in communication.

Staff meetings were held to keep staff updated with any changes within the home and to discuss any issues. A member of staff commented, "Nurse meetings have started since the new manager came and these have been useful." The registered manager told us daily head of department meetings were held and weekly staff meetings to improve communication within the home.

Relatives told us meetings were held for people and relatives. A meeting had taken place 22 January 2015. One relative said, "I know they take place but I haven't attended. " Another relative said, "At the last meeting we discussed forming an activities committee to help get more ideas for activities."

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people. A relative told us, "I was sent a questionnaire to fill in about the home last summer." We saw copies of the surveys of the quality assurance audit for October 2014 where 18 replies were received from the surveys which had been sent out to everyone in the service. The registered manager told us the results were analysed by the service. We saw findings from the survey were positive and where suggestions for improvement were made action was taken to try and address the issues.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity and falls and mobility. Although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted certain aspects of record keeping such as care planning, medicines management and risk assessments to ensure they contained accurate information so people received care in the way they wanted and needed.

Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. The registered manager told us monthly visits were carried out by the head of operations and the quality assurance manager to check on the quality of care being provided by the service. A financial audit was carried out by a representative from head office annually. These were carried out to ensure the care and safety of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Records did not always accurately reflect people's care and support needs.**